A. MANAGED HEALTHCARE OPTIONS

Purpose: This section explains how DSHS manages healthcare for certain clients. There are three basic types of managed care:

1. **Enrollment with a managed care organization** (MCO) – which includes both health plans and HMOs. This type of managed care is also called "Healthy Options." Under this type of managed care, the department contracts with MCOs to deliver the majority of medical services to certain eligible clients. The department pays a monthly premium to the MCO to cover most medical services.

2. **Enrollment with a primary care case management (PCCM) provider**. The client's medical care is managed and coordinated by one medical provider. There are different types of PCCM:

    a. Clients who are American Indians / Alaska Natives (AI / AN) can enroll with Indian Health Services, Tribal or Urban Indian Clinics to have their health care coordinated. AI/AN clients can enroll in Healthy Options or they may choose not to have managed care.

    b. A client can choose to enroll in the Washington State Health Network (WSHN), where the client's medical care is managed and coordinated by one medical provider. Under WSHN, the department is not required to cover services that are not approved by the client's medical care provider.

3. Patients requiring regulation. This program is discussed in Section B. of this category.

NOTE: In geographic areas where there are two or more MCOs or a combination of MCO and WSHN choices, clients eligible under specific medical eligibility codes must enroll in managed care described in 2. a. and 2. b. above.

Effective January 14, 2002

WAC 388-538-050 Definitions.

The following definitions and abbreviations and those found in chapter 388-500-0005 WAC, Medical definitions, apply to this chapter.

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"Ancillary health services" means health services ordered by a provider, including but not limited to, laboratory services, radiology services, and physical therapy.

"Appeal" means a formal request by a provider or covered enrollee for reconsideration of a decision such as a utilization review recommendation, a benefit payment, an administrative action, or a quality of care or service issue, with the goal of finding a mutually acceptable solution.

"Assign" or **"assignment"** means that MAA selects a managed care organization (MCO) or primary care case management (PCCM) provider to serve a client who lives in a mandatory enrollment area and who has failed to select an MCO or PCCM provider.

"Basic health (BH)" means the health care program authorized by title 70.47 RCW and administered by the health care authority (HCA). MAA considers basic health to be third-party coverage, however, this does not include basic health plus (BH.+).

"Children's health insurance program (CHIP)" means the health insurance program authorized by Title XXI of the Social Security Act and administered by the department of social and health services (DSHS). This program also is referred to as the state children's health insurance program (SCHIP).

"Children with special health care needs" means children identified by the department of social and health services (DSHS) as having special health care needs. This includes:

(1) Children designated as having special health care needs by the department of health (DOH) and served under the Title V program;

(2) Children who meet disability criteria of Title 16 of the Social Security Act (SSA); and

(3) Children who are in foster care or who are served under subsidized adoption.

"Client" means an individual eligible for any medical program who is not enrolled with a managed care organization (MCO) or primary care case management (PCCM) provider. In this chapter, client refers to a person before the person is enrolled in managed care, while enrollee refers to an individual eligible for any medical program who is enrolled in managed care.

"Complaint" means an oral or written expression of dissatisfaction by an enrollee.

"Emergency medical condition" means a condition meeting the definition in 42 U.S.C. 1396u-2 (b)(2)(C).

"Emergency services" means services as defined in 42 U.S.C. 1396u-2 (b)(2)(B).

"End enrollment" means an enrollee is currently enrolled in managed care, either with a

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managed care organization (MCO) or with a primary care case management (PCCM) provider, and requests to discontinue enrollment and return to the fee-for-service delivery system for one of the reasons outlined in WAC 388-538-130. This is also referred to as "disenrollment."

"Enrollee" means an individual eligible for any medical program who is enrolled in managed care through a managed care organization (MCO) or primary care case management (PCCM) provider that has a contract with the state.

"Enrollees with chronic conditions" means persons having chronic and disabling conditions, including persons with special health care needs that meet all of the following conditions:

(1) Have a biologic, psychologic, or cognitive basis;

(2) Have lasted or are virtually certain to last for at least one year; and

(3) Produce one or more of the following conditions stemming from a disease:

  (a) Significant limitation in areas of physical, cognitive, or emotional function;

  (b) Dependency on medical or assistive devices to minimize limitation of function or activities; or

  (c) In addition, for children, any of the following:

    (i) Significant limitation in social growth or developmental function;

    (ii) Need for psychologic, educational, medical, or related services over and above the usual for the child's age; or

    (iii) Special ongoing treatments, such as medications, special diet, interventions, or accommodations at home or school.

"Exemption" means a client, not currently enrolled in managed care, makes a pre-enrollment request to remain in the fee-for-service delivery system for one of the reasons outlined in WAC 388-538-080.

"Health care service" or **"service"** means a service or item provided for the prevention, cure, or treatment of an illness, injury, disease, or condition.

"Healthy options contract or HO contract" means the agreement between the department of social and health services (DSHS) and a managed care organization (MCO) to provide prepaid contracted services to enrollees.

"Healthy options program or HO program" means the medical assistance administration's (MAA) prepaid managed care health program for Medicaid-eligible clients

and CHIP clients.

"Managed care" means a comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. These services are provided either through a managed care organization (MCO) or primary care case management (PCCM) provider.

"Managed care organization" or **"MCO"** means a health maintenance organization or health care service contractor that contracts with the department of social and health services (DSHS) under a comprehensive risk contract to provide prepaid health care services to eligible medical assistance administration (MAA) clients under MAA's managed care programs.

"Nonparticipating provider" means a person or entity that does not have a written agreement with a managed care organization (MCO) but that provides MCO-contracted health care services to managed care enrollees with the authorization of the MCO. The MCO is solely responsible for payment for MCO-contracted health care services that are authorized by the MCO and provided by nonparticipating providers.

"Participating provider" means a person or entity with a written agreement with a managed care organization (MCO) to provide health care services to managed care enrollees. A participating provider must look solely to the MCO for payment for such services.

"Primary care case management (PCCM)" means the health care management activities of a provider that contracts with the department to provide primary health care services and to arrange and coordinate other preventive, specialty, and ancillary health services.

"Primary care provider (PCP)" means a person licensed or certified under Title 18 RCW including, but not limited to, a physician, an advanced registered nurse practitioner (ARNP), or a physician assistant who supervises, coordinates, and provides health services to a client or an enrollee, initiates referrals for specialist and ancillary care, and maintains the client's or enrollee's continuity of care.

"Prior authorization (PA)" means a process by which enrollees or providers must request and receive MAA approval for certain medical services, equipment, drugs, and supplies, based on medical necessity, before the services are provided to clients, as a precondition for provider reimbursement. Expedited prior authorization and limitation extension are forms of prior authorization. See WAC 388-501-0165.

"Timely" - in relation to the provision of services, means an enrollee has the right to receive medically necessary health care without unreasonable delay.

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WAC 388-538-060 Healthy options and choice.

(1) A client is required to enroll in managed care when that client meets all of the following conditions:

(a) Is eligible for one of the medical programs for which clients must enroll in managed care;

(b) Resides in an area, determined by the medical assistance administration (MAA), where clients must enroll in managed care;

(c) Is not exempt from managed care enrollment as determined by MAA, consistent with WAC 388-538-080, and any related fair hearing has been held and decided; and

(d) Has not had managed care enrollment ended by MAA, consistent with WAC 388-538-130.

(2) American Indian/Alaska Native (AI/AN) clients who meet the provisions of 25 U.S.C. 1603 (c)-(d) for federally-recognized tribal members and their descendants may choose one of the following:

(a) Enrollment with a managed care organization (MCO) available in their area;

(b) Enrollment with an Indian or tribal primary care case management (PCCM) provider available in their area; or

(c) MAA's fee-for-service system.

(3) A client may enroll with an MCO or PCCM provider by calling MAA's toll-free enrollment line or by sending a completed enrollment form to MAA.

(a) Except as provided in subsection (2) of this section for clients who are AI/AN and in subsection (5) of this section for cross-county enrollment, a client

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provider available in the area where the client lives.

(b) All family members must either enroll with the same MCO or enroll with PCCM providers.

(c) Enrollees may request an MCO or PCCM provider change at any time.

(d) When a client requests enrollment with an MCO or PCCM provider, MAA enrolls a client effective the earliest possible date given the requirements of MAA's enrollment system. MAA does not enroll clients retrospectively.

(4) MAA assigns a client who does not choose an MCO or PCCM provider as follows:

(a) If the client has family members enrolled with an MCO, the client is enrolled with that MCO;

(b) If the client does not have family members enrolled with an MCO, and the client was enrolled in the last six months with an MCO or PCCM provider, the client is re-enrolled with the same MCO or PCCM provider;

(c) If a client does not choose an MCO or a PCCM provider, but indicates a preference for a provider to serve as the client's primary case provider (PCP), MAA attempts to contact the client to complete the required choice. If MAA is not able to contact the client in a timely manner, MAA documents the attempted contacts and, using the best information available, assigns the client as follows. If the client's preferred PCP is:

(i) Available with one MCO, MAA assigns the client in the MCO where the client's PCP provider is available. The MCO is responsible for PCP choice and assignment;

(ii) Available only as a PCCM provider, MAA assigns the client to the preferred provider as the client's PCCM provider;

(iii) Available with multiple MCOs or through an MCO and as a PCCM provider, MAA assigns the client to an MCO as described in (d) of this subsection;

(iv) Not available through any MCO or as a PCCM provider, MAA assigns the client to an MCO or PCCM provider as described in (d) of this subsection.

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MAA assigns the client as follows:

(i) If an AI/AN client does not choose an MCO or PCCM provider, MAA assigns the client to a tribal PCCM provider if that client lives in a zip code served by a tribal PCCM provider. If there is no tribal PCCM provider in the client's area, the client continues to be served by MAA's fee-for-service system. A client assigned under this subsection may request to end enrollment at any time.

(ii) If a non-AI/AN client does not choose an MCO or PCCM provider, MAA assigns the client to an MCO or PCCM provider available in the area where the client lives. The MCO is responsible for PCP choice and assignment. An MCO must meet the healthy options (HO) contract's access standards unless the MCO has been granted an exemption by MAA. The HO contract standards are as follows:

(A) There must be two PCPs within ten miles for ninety percent of HO enrollees in urban areas and one PCP within twenty-five miles for ninety percent of HO enrollees in rural areas;

(B) There must be two obstetrical providers within ten miles for ninety percent of HO enrollees in urban areas and one obstetrical provider within twenty-five miles for ninety percent of HO enrollees in rural areas;

(C) There must be one hospital within twenty-five miles for ninety percent of HO enrollees in the contractor's service area;

(D) There must be one pharmacy within ten miles for ninety percent of HO enrollees in urban areas and one pharmacy within twenty-five miles for ninety percent of HO enrollees in rural areas.

(iii) MAA sends a written notice to each household of one or more clients who are assigned to an MCO or PCCM provider. The notice includes the name of the MCO or PCCM provider to which each client has been assigned, the effective date of enrollment, the date by which the client must respond in order to change MAA's assignment, and either the toll-free telephone number of:

(A) The MCO for enrollees assigned to an MCO; or

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(B) MAA for enrollees assigned to a PCCM provider.

(iv) An assigned client has at least thirty calendar days to contact MAA to change the MCO or PCCM provider assignment before enrollment is effective.

(5) A client may enroll with a plan in an adjacent county when the client lives in an area, designated by MAA, where residents historically have traveled a relatively short distance across county lines to the nearest available practitioner.

(6) An MCO enrollee's selection of the enrollee's PCP or the enrollee's assignment to a PCP occurs as follows:

(a) MCO enrollees may choose:

(i) A PCP or clinic that is in the enrollee's MCO and accepting new enrollees; or

(ii) Different PCPs or clinics participating with the same MCO for different family members.

(b) The MCO assigns a PCP or clinic that meets the access standards set forth in subsection (4)(d)(ii) of this section if the enrollee does not choose a PCP or clinic;

(c) MCO enrollees may change PCPs or clinics in an MCO at least once a year for any reason, and at any time for good cause; or

(d) In accordance with this subsection, MCO enrollees may file an appeal with the MCO and/or a fair hearing request with the department of social and health services (DSHS) and may change plans if the MCO denies an

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WAC 388-538-065 Medicaid-eligible basic health (BH) enrollees.

(1) Certain children and pregnant women who have applied for, or are enrolled in, managed care through basic health (BH) (chapter 70.47 RCW) are eligible for Medicaid under pediatric and maternity expansion provisions of the Social Security Act. The medical assistance administration (MAA) determines Medicaid eligibility for children and pregnant women who enroll through BH.

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(2) The administrative rules and regulations that apply to managed care enrollees also apply to Medicaid-eligible clients enrolled through BH, except as follows:

(a) The process for enrolling in managed care described in WAC 388-538-060 (3) does not apply since enrollment is through the health care authority, the state agency that administers BH;

(b) American Indian/Alaska Native (AI/AN) clients cannot choose fee-for-service or PCCM as described in WAC 388-538-060 (2). They must enroll in a BH-contracted MCO.

(c) If a Medicaid eligible client applying for BH does not choose an MCO within ninety days, the client is transferred from BH to the department of social and health services (DSHS) for assignment to managed care.

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WAC 388-538-067 Managed care provided through managed care organizations (MCOs).

(1) Managed care organizations (MCOs) may contract with the department of social and health services (DSHS) to provide prepaid health care services to eligible medical assistance administration (MAA) clients under the healthy options (HO) managed care program. The MCOs must meet the qualifications in this section to be eligible to contract with DSHS. The MCO must:

(a) Have a certificate of registration from the office of the insurance commissioner (OIC) as either a health maintenance organization (HMO) or a health care services contractor (HCSC).

(b) Accept the terms and conditions of DSHS' HO contract;

(c) Be able to meet the network and quality standards established by DSHS; and

(d) Accept the prepaid rates published by DSHS.

(2) DSHS reserves the right not to contract with any otherwise qualified MCO.

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WAC 388-538-068 Managed care provided through primary care case management (PCCM).

(1) A provider may contract with DSHS as a primary care case management (PCCM) provider to provide health care services to eligible medical assistance administration (MAA) clients under MAA's managed care program. The PCCM provider or the individual providers in a PCCM group or clinic must:

(a) Have a core provider agreement with DSHS;

(b) Hold a current license to practice as a physician, certified nurse midwife, or advanced registered nurse practitioner in the state of Washington;

(c) Accept the terms and conditions of DSHS' PCCM contract;

(d) Be able to meet the quality standards established by DSHS; and

(e) Accept PCCM rates published by DSHS.

(2) DSHS reserves the right not to contract for PCCM with an otherwise qualified provider.

WAC 388-538-070 Managed care payment.

(1) The medical assistance administration (MAA) pays managed care organizations (MCOs) monthly capitated premiums that:

(a) Have been determined using generally accepted actuarial methods based on analyses of historical healthy options (HO) contractual rates and MCO experience in providing health care for the populations eligible for HO; and

(b) Are paid based on legislative allocations for the HO program.

(2) MAA pays primary care case management (PCCM) providers a monthly case

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management fee according to contracted terms and conditions.

(3) MAA does not pay providers on a fee-for-service basis for services that are the MCO's responsibility under the HO contract, even if the MCO has not paid for the service for any reason. The MCO is solely responsible for payment of MCO-contracted health care services:

(a) Provided by an MCO-contracted provider; or

(b) That are authorized by the MCO and provided by nonparticipating providers.

(4) MAA pays an additional monthly amount, known as an enhancement rate, to federally qualified health care centers (FQHC) and rural health clinics (RHC) for each client enrolled with MCOs through the FQHC or RHC. MCOs may contract with FQHCs and RHCs to provide services under HO. FQHCs and RHCs receive an enhancement rate from MAA on a per member, per month basis in addition to the negotiated payments they receive from the MCOs for services provided to MCO enrollees.

(a) MAA pays the enhancement rate only for the categories of service provided by the FQHC or RHC under the HO contact [contract]. MAA surveys each FQHC or RHC in order to identify the categories of services provided by the FQHC or RHC.

(b) MAA bases the enhancement rate on both of the following:

(i) The upper payment limit (UPL) for the county in which the FQHC or RHC is located; and

(ii) An enhancement percentage.

(c) MAA determines the UPL for each category of service based on MAA's historical fee-for-service (FFS) experience, adjusted for inflation and utilization changes.

(d) MAA determines the enhancement percentage for HO enrollees as follows:

(i) For FQHCs, the enhancement percentage is equal to the FQHC finalized audit period ratio. The "finalized audit period" is the latest reporting period for which the FQHC has a completed audit approved by, and settled with, MAA.

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(FQHC total costs) - (FFS reimbursements + HO reimbursements)/(FFS + HO reimbursements).

(B) For a clinic with two finalized audit periods, the ratio is equal to the percentage change in the medical services encounter rate from one finalized audit period to the next. A "medical services encounter" is a face-to-face encounter between a physician or mid-level practitioner and a client to provide services for prevention, diagnosis, and/or treatment of illness or injury. A "medical services encounter rate" is the individualized rate MAA pays each FQHC to provide such services to clients, or the rate set by Medicare for each RHC for such services.

(C) For FQHCs without a finalized audit, the enhancement percentage is the statewide weighted average of all the FQHCs' finalized audit period ratios. Weighting is based on the number of enrollees served by each FQHC.

(ii) For RHCs, MAA applies the same enhancement percentage statewide.

(A) On a given month, MAA determines the number of HO enrollees enrolled with each RHC that is located in the same county as an FQHC. This number is expressed as a percentage of the total number of RHC enrollees located in counties that have both FQHCs and RHCs.

(B) For each county that has both an FQHC and an RHC, MAA multiplies the FQHC enhancement percentage, as determined under subsection (4)(d)(i) of this section, by the percentage obtained in section (4)(d)(ii)(A) of this section.
(C) The sum of all these products is the weighted statewide RHC enhancement percentage.

(iii) The HO enhancement percentage for FQHCs and RHCs is updated once a year.

(e) For each category of service provided by the FQHC or RHC, MAA multiplies the UPL, as determined under subsection (4)(c) of this section, by the FQHC's or RHC's enhancement percentage. The sum of all these products is the enhancement rate for the individual FQHC or RHC.

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(f) To calculate the enhancement rate for FQHCs and RHCs that provide maternity and newborn delivery services, MAA applies each FQHC's or RHC's enhancement percentage to the delivery case rate (DCR), which is a one-time rate paid by MAA to the HO plan for each pregnant enrollee who gives birth.

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WAC 88-538-080 Managed care exemptions.

(1) The medical assistance administration (MAA) exempts a client from mandatory enrollment in managed care if MAA becomes aware of the following conditions. The client:

(a) Is receiving foster care placement services from the division of children and family services (DCFS); or

(b) Has Medicare, basic health (BH), CHAMPUS/TRICARE, or other accessible third-party health care coverage that would require exemption from enrollment with:

(i) A managed care organization (MCO) in accordance with MAA's healthy options (HO) contract requirements for MCO enrollment; or

(ii) (ii) A primary care case management provider (PCCM) in accordance with MAA's PCCM contract requirements for PCCM enrollment.

(2) Only a client or a client's representative (RCW 7.70.065) may request an exemption from managed care enrollment for reasons other than those stated in subsection (1) of this section. If a client asks for an exemption prior to the enrollment effective date, the client is not enrolled until MAA approves or denies the request and any related fair hearing is held and decided.

(3) MAA grants a client's request for an exemption from mandatory enrollment in managed care if any of the following apply:

(a) The client has a documented and verifiable medical need to continue a

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client/provider relationship due to an established course of care with a physician, physician assistant or advanced registered nurse practitioner. MAA accepts the established provider's signed statement that the client has:

(i) A medical need that requires a continuation of the established care relationship; and

(ii) The client's established provider is not available through any managed care organization (MCO) or as a primary care case management (PCCM) provider.

(b) Prior to enrollment, the client scheduled a surgery with a provider not available to the client through managed care and the surgery is scheduled within the first thirty days of enrollment; or

(c) The client is American Indian/Alaska Native (AI/AN) as specified in WAC 388-538-060 (2) and requests exemption; or

(d) The client has been identified by MAA as having special needs that meet MAA's definition of children with special health care needs and requests exemption; or

(e) The client is pregnant and wishes to continue her established course of prenatal care with an obstetrical provider who is not available to her through managed care; or

(f) On a case-by-case basis, the client presents evidence that managed care does not provide medically necessary care that is reasonably available and accessible as offered to the client. MAA considers that medically necessary care is not reasonably available and accessible when any of the following apply:

(i) The client is homeless or is expected to live in temporary housing for less than one hundred twenty days from the date the client requests the exemption;

(ii) The client speaks limited English or is hearing impaired and the client can communicate with a provider who communicates in the client's language or in American Sign Language and is not available through

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managed care;

(iii) The client shows that travel to a managed care PCP is unreasonable when compared to travel to a non-managed care primary care provider (PCP). This is shown when any of the following transportation situations apply to the client:

(A) It is over twenty-five miles one-way to the nearest managed care PCP who is accepting enrollees, and the client's PCP is closer and not in an available plan;

(B) The travel time is over forty-five minutes one-way to the nearest managed care PCP who is accepting enrollees, and the travel time to the client's PCP, who is not available in an MCO or as a PCCM provider, is less;

(C) Other transportation difficulties make it unreasonable to get primary medical services under HO; or

(iv) Other evidence is presented that an exemption is appropriate based on the client's circumstances, as evaluated by MAA.

(4) MAA exempts the client for the time period the circumstances or conditions that led to the exemption are expected to exist. If the request is approved for a limited time, the client is notified in writing or by telephone of the time limitation, the process for renewing the exemption, and the client's fair hearing rights.

(5) The client is not enrolled as provided in subsection (2) of this section and receives timely notice by telephone or in writing when MAA approves or denies the client's exemption request. If initial denial notice was by telephone, then MAA gives the reasons for the denial in writing before requiring the client to enroll in managed care. The written notice to the client contains all of the following:

(a) The action MAA intends to take, including enrollment information;

(b) The reason(s) for the intended action;

(c) The specific rule or regulation supporting the action;

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(d) The client's right to request a fair hearing, including the circumstances under which the fee-for-service status continues, if a hearing is requested; and

(e) A translation into the client's primary language when the client has limited English proficiency.

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WAC 388-538-095 Scope of care for managed care enrollees.

(1) Managed care enrollees are eligible for the scope of medical care as described in WAC 388-529-0100 for categorically needy clients.

(a) A client is entitled to timely access to medically necessary services as defined in WAC 388-500-0005.

(b) The managed care organization (MCO) covers the services included in the healthy options (HO) contract for MCO enrollees. In addition, MCOs may, at their discretion, cover services not required under the HO contract.

(c) The medical assistance administration (MAA) covers the categorically needy services not included in the HO contract for MCO enrollees.

(d) MAA covers services on a fee-for-service basis for enrollees with a primary care case management (PCCM) provider. Except for emergencies, the PCCM provider must either provide the covered services needed by the enrollee or refer the enrollee to other providers who are contracted with MAA for covered services. The PCCM provider is responsible for instructing the enrollee regarding how to obtain the services that are referred by the PCCM provider. The services that require PCCM provider referral are described in the PCCM contract. MAA informs enrollees about the enrollee's program coverage, limitations to covered services, and how to obtain covered services.

(e) MCO enrollees may obtain certain services from either a MCO provider or from a medical assistance provider with a DSHS core provider agreement without needing to obtain a referral from the PCP or MCO. These services are described in the HO contract. and are communicated to enrollees by

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MAA and MCOs as described in (f) of this subsection.

(f) MAA sends each client written information about covered services when the client is required to enroll in managed care, and any time there is a change in covered services. This information describes covered services, which services are covered by MAA, and which services are covered by MCOs. In addition, MAA requires MCOs to provide new enrollees with written information about covered services.

(2) For services covered by MAA through PCCM contracts for managed care:

(a) MAA medically necessary covers services included in the categorically needy scope of care and rendered by providers with a current department of social and health services (DSHS) core provider agreement to provide the requested service;

(b) MAA may require the PCCM provider to obtain authorization from MAA for coverage of nonemergency services;

(c) The PCCM provider determines which services are medically necessary;

(d) An enrollee may request a fair hearing for review of PCCM provider or MAA coverage decisions; and

(e) Services referred by the PCCM provider require an authorization number in order to receive payment from MAA.

(3) For services covered by MAA through contracts with MCOs:

(a) MAA requires the MCO to subcontract with a sufficient providers to deliver the scope of contracted services in a timely manner. Except for emergency services, MCOs provide covered services to enrollees through their participating providers;

(b) MAA requires MCOs to provide new enrollees with written information about how enrollees may obtain covered services;

(c) For nonemergency services, MCOs may require the enrollee to obtain a referral from the primary care provider (PCP), or the provider to obtain

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authorization from the MCO, according to the requirements of the HO contract;

(d) MCOs and their providers determine which services are medically necessary given the enrollee's condition, according to the requirements included in the HO contract;

(e) An enrollee may appeal an MCO coverage decisions using the MCO's appeal process, as described in WAC 388-538-0110. [Ed. Note: This reference is incorrect. The correct reference is WAC 388-538-110.] An enrollee may also request a hearing for review of an MCO coverage decision as described in chapter 388-02 WAC;

(f) A managed care enrollee does not need a PCP referral to receive women's health care services, as described in RCW 48.42.100 from any women's health care provider participating with the MCO. Any covered services ordered and/or prescribed by the women's health care provider must meet the MCO's service authorization requirements for the specific service.

(4) Unless the MCO chooses to cover these services, or an appeal or a fair hearing decision reverses an MCO or MAA denial, the following services are not covered:

(a) For all managed care enrollees:

(i) Services that are not medically necessary;

(ii) Services not included in the categorically needy scope of services; and

(iii) Services, other than a screening exam as described in WAC 388-538-100 (3), received in a hospital emergency department for nonemergency medical conditions.

(b) For MCO enrollees:

(i) Services received from a participating specialist that require prior authorization from the MCO, but were not authorized by the MCO; and

(ii) Services received from a nonparticipating provider that require prior

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authorization from the MCO that were not authorized by the MCO. All nonemergency services covered under the HO contract and received from nonparticipating providers require prior authorization from the MCO.

(c) For PCCM enrollees, services that require a referral from the PCCM provider as described in the PCCM contract, but were not referred by the PCCM provider.

(5) A provider may bill an enrollee for noncovered services as described in subsection (4) of this section, if the enrollee and provider sign an agreement. The provider must give the original agreement to the enrollee and file a copy in the enrollee's record.

(a) The agreement must state all of the following:

(i) The specific service to be provided;

(ii) That the service is not covered by either MAA or the MCO;

(iii) An explanation of why the service is not covered by the MCO or MAA, such as:

(A) The service is not medically necessary; or

(B) The service is covered only when provided by a participating provider.

(iv) The enrollee chooses to receive and pay for the service; and

(v) Why the enrollee is choosing to pay for the service, such as:

(A) The enrollee understands that the service is available at no cost from a provider participating with the MCO, but the enrollee chooses to pay for the service from a provider not participating with the MCO;

(B) The MCO has not authorized emergency department services for nonemergency medical conditions and the enrollee chooses to pay for the emergency department's services

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rather than wait to receive services at no cost in a participating provider's office; or

(C) The MCO or PCCM has determined that the service is not medically necessary and the enrollee chooses to pay for the service.

(b) For limited English proficient enrollees, the agreement must be translated or interpreted into the enrollee's primary language to be valid and enforceable.

(a) The agreement is void and unenforceable, and the enrollee is under no obligation to pay the provider, if the service is covered by MAA or the MCO as described in subsection (1) of this section, even if the provider is not paid for the covered service because the provider did not satisfy the payor's billing requirements.

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Effective January 14, 2002

WAC 388-538-100 Managed care emergency services.

(1) A managed care enrollee may obtain emergency services, for emergency medical conditions in any hospital emergency department. These definitions differ from the emergency services definition that applies to services covered under the medical assistance administration's (MAA's) fee-for-service system.

(a) The managed care organization (MCO) covers emergency services for MCO enrollees.

(b) MAA covers emergency services for primary care case management (PCCM) enrollees.

(2) Emergency services for emergency medical conditions do not require prior authorization by the MCO, primary care provider (PCP), PCCM provider, or MAA.

(3) Emergency services received by an MCO enrollee for nonemergency medical conditions must be authorized by the plan for enrollee's MCO.

(4) An enrollee who requests emergency services is entitled to receive an exam to determine if the enrollee has an emergency medical condition.

Effective January 14, 2002

WAC 388-538-110 Managed care complaints, appeals, and fair hearings.

(1) A managed care enrollee has the right to voice a complaint or submit an appeal of an MAA, MCO, PCCM, PCP or provider decision, action, or inaction. An enrollee may do this through the following process:

(a) For managed care organization (MCO) enrolles [enrollees], the MCO's complaint and appeal processes, and through the department's fair hearing process; or

(b) For primary care case management (PCCM) enrollees, the complaint and appeal processes of the medical assistance administration (MAA), and through the department's fair hearing process (chapter 388-02 WAC).

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(2) To ensure the rights of MCO enrollees are protected, MAA approves each MCO's complaint and appeal policies and procedures annually or whenever the plan makes a change to the process.

(3) MAA requires MCOs to inform MCO enrollees in writing within fifteen days of enrollment about their rights and how to use the MCO's complaint and appeal processes. MAA requires MCOs to obtain MAA approval of all written information sent to enrollees.

(4) MAA provides PCCM enrollees with information equivalent to that described in subsection (3) of this section.

(5) MCO enrollees may request assistance from the MCO when using the MCO's complaint and appeals processes. PCCM enrollees may request assistance from MAA when using MAA's complaint and appeal process.

(6) An MCO enrollee who submits a complaint under this section is entitled to a written or verbal response from the MCO or from MAA within the timeline in the MAA-approved complaint process.

(7) When an enrollee is not satisfied with how the complaint is resolved by the MCO or by MAA, or if the complaint is not resolved in a timely fashion, the enrollee may submit an appeal to the MCO or to MAA. An enrollee may also appeal an MAA, MCO, primary care provider (PCP), or provider decision, or reconsideration of any action or inaction. An enrollee who appeals an MAA, MCO, PCP, or provider decision is entitled to all of the following:

(a) A review of the decision being appealed. The review must be conducted by an MCO or MAA representative who was not involved in the decision under appeal;

(b) Continuation of the service already being received and which is under appeal, until a final decision is made;

(c) A written decision from MAA or the MCO, within the timeline(s) in the appeal process standards, in the enrollee's primary language. The decision does not need to be translated if an enrollee with limited English proficiency prefers correspondence in English, and the deciding authority documents the

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enrollee's preference. The notice must clearly explain all of the following:

(i) The decision and any action MAA or the MCO intends to take;

(ii) The reason for the decision;

(iii) The specific information that supports MAA's or the MCO's decision; and

(iv) Any further appeal or fair hearing rights available to the enrollee, including the enrollee's right to continue receiving the service under appeal until a final decision is made.

(d) An expedited decision when it is necessary to meet an existing or anticipated acute or urgent medical need.

(8) An enrollee may file a fair hearing request without also filing an appeal with MAA or the MCO or exhausting MAA's or the MCO's appeal process.

(9) The MCO's medical director or designee reviews all fair hearings requests, and any related appeals, when the issues involve an MCO's determination of medical necessity.

(10) MAA's medical director or the medical director's designee reviews all fair hearings requests, and any related appeals, when the PCCM enrollee's issues involve an MAA determination of medical necessity.

Effective January 14, 2002

WAC 388-538-120 Enrollee request for a second medical opinion.

(1) A **managed care** enrollee has the right to a timely referral for a second opinion upon request when:

(a) The enrollee needs more information about treatment recommended by the provider or managed care organization (MCO); or

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(b) The enrollee believes the MCO is not authorizing medically necessary care.

(2) A managed care enrollee has a right to a second opinion from a primary or specialty care physician who is participating with the MCO. At the MCO's discretion, a clinically appropriate nonparticipating provider who is agreed upon by the MCO and the enrollee may provide the second opinion.

(3) Primary care case management (PCCM) provider enrollees have a right to a timely referral for a second opinion by another provider who has a core provider agreement with medical assistance administration (MAA).

WAC 388-538-130 Ending enrollment in managed care.

(1) MAA ends an enrollee's enrollment in a managed care organization (MCO) or with a primary care case management (PCCM) provider when the enrollee meets any of the following conditions. The enrollee:

(a) Is no longer eligible for a medical program subject to enrollment; or

(b) Is receiving foster care placement services from the division of children and family services; or

(c) Is or becomes eligible for Medicare, basic health (BH), CHAMPUS/TRICARE, or any other accessible third party health care coverage that would require involuntary disenrollment from:

(i) An MCO in accordance with MAA's healthy options (HO) contract for MCO enrollees; or

(ii) A PCCM provider in accordance with MAA's PCCM contract for PCCM enrollees.

(2) An enrollee or the enrollee's representative as defined in RCW 7.70.065 may request MAA to end enrollment as described in subsections (3) through (10) of this section. A managed care organization (MCO) may request MAA to end enrollment for an enrollee as described in subsection (11) of this section. Only

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MAA has authority to remove an enrollee from managed care. Pending MAA's final decision, the enrollee remains enrolled unless staying in managed care would adversely affect the enrollee's health status.

(3) MAA grants an enrollee's request to have the enrollee's enrollment ended under the following conditions:

(a) Is American Indian or Alaska Native (AI/AN) and requests disenrollment; or

(b) Is identified by DSHS as a child who meets the definition of "children with special health care needs" and requests disenrollment.

(4) MAA grants an enrollee's requests to be removed from managed care when the client is pregnant or when there is a verified medical need to continue an established course of care. These end enrollments are limited to the following situations: The enrollee:

(a) Has a documented medical need to continue a client/provider relationship due to an established course of care with a physician, physician assistant, or advanced registered nurse practitioner. The standards for documenting a medical need are those in WAC 388-538-080 (3)(a). The established course of care must begin:

(i) While the enrollee was enrolled with managed care but the PCP is no longer available to the enrollee under managed care; or

(ii) Prior to enrollment in managed care and the PCP is not available under any MCO or as a PCCM provider.

(b) Is pregnant and requests to continue her course of prenatal care that was established with an obstetrical provider:

(i) While she was enrolled with the MCO but that provider is no longer available to her in managed care; or

(ii) Prior to enrollment with the current MCO but that provider is not available to her under managed care.

(c) Is scheduled for a surgery with a provider not available to the enrollee in the

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enrollee's current MCO and the surgery is scheduled to be performed within the first thirty days of enrollment[.]

(5) Except as provided in subsection (4) of this section, MAA does not permit an enrollee to obtain an end enrollment by establishing a course of care with a provider who is not participating with the enrollee's MCO.

(6) MAA ends enrollment on a case-by-case basis when the enrollee presents evidence that the managed care program does not provide medically necessary care that is reasonable available and accessible as offered to the enrollee. MAA considers enrollee requests under this subsection with the same criteria as listed in WAC 388-538-080 (3)(f).

(7) MAA ends enrollment temporarily if an enrollee asks to be taken out of the current MCO in order to stay with the enrollee's established provider, but is willing to enroll in the established provider's MCO for the next enrollment month. MAA reviews the enrollee request according to the criteria in subsections (4) and (6) of this section. MAA's decision under this subsection include all of the following:

(a) The decision is given verbally and in writing;

(b) Verbal and written notices include the reason for the decision and information on hearings so the enrollee may appeal the decision;

(c) If the request to end enrollment is approved, it may be effective back to the beginning of the month the request is made; and

(d) If the request to end enrollment is denied, and the enrollee requests a hearing; the enrollee remains in the MCO or with the PCCM until the hearing decision is made as provided in subsection (2) of this section.

(8) MAA ends enrollment for the period of time the circumstances or conditions that led to ending the enrollment are expected to exist. If the request to end enrollment is approved for a limited time, the client is notified in writing or by telephone of the time limitation, the process for renewing the disenrollment, and their fair hearing rights.

(9) MAA does not approve an enrollee's request to end enrollment solely to pay for services received but not authorized by the MCO.

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(10) The enrollee remains in managed care as provided in subsection (1) of this section and receives timely notice by telephone or in writing when MAA approves or denies the enrollee's request to end enrollment. Except as provided in subsection (7) of this section, MAA gives the reasons for a denial in writing. The written denial notice to the enrollee contains all of the following:

(a) The action MAA intends to take;

(b) The reason(s) for the intended action;

(c) The specific rule or regulation supporting the action;

(d) The enrollee's right to request a fair hearing; and

(e) A translation into the enrollee's primary language when the enrollee has limited English proficiency.

(11) MAA may end an enrollee's enrollment in a MCO or with a PCCM provider when the enrollee's MCO or PCCM provider substantiates in writing, to MAA's satisfaction, that:

(a) The enrollee's behavior is inconsistent with the MCO or PCCM provider rules and regulations, such as intentional misconduct; and

(b) After the MCO or PCCM provider has provided:

(i) Clinically appropriate evaluation(s) to determine whether there is a treatable problem contributing to the enrollee's behavior; and

(ii) If so, has provided clinically appropriate referral(s) and treatment(s), but the enrollee's behavior continues to prevent the provider from safely or prudently providing medical care to the enrollee; and

(c) The enrollee received written notice from the MCO or PCCM provider of the MCO or PCCM provider intent to request the enrollee's removal, unless MAA has waived the requirement for the MCO or PCCM provider notice because the enrollee's conduct presents the threat of imminent harm to others. The MCO or PCCM provider notice to the enrollee must include

both of the following:

(i) The enrollee's right to use the appeal process as described in WAC 388-538-110 to review the MCO or PCCM provider request to end the enrollee's enrollment; and

(ii) The enrollee's right to use the department fair hearing process.

(12) MAA makes a decision to remove an enrollee from enrollment in managed care within thirty days of receiving the MCO or PCCM provider request to do so. Before making a decision, MAA attempts to contact the enrollee and learn the enrollee's perspective. If MAA approves the MCO or PCCM provider request to remove the enrollee, MAA sends a notice at least ten days in advance of the effective date that enrollment will end. The notice includes the reason for MAA's approval to end enrollment and information about the enrollee's fair hearing rights.

(13) MAA does not approve a request to remove an enrollee from managed care when the request is solely due to an adverse change in the enrollee's health or the cost of meeting the enrollee's needs.

Effective January 14, 2002

WAC 388-538-140 Quality of care.

(1) In order to assure that managed care enrollees receive appropriate access to quality health care and services, the medical assistance administration (MAA) does all of the following:

(a) Requires managed care organizations (MCOs) to have a fully operational quality assurance system that meets a comprehensive set of quality improvement program (QIP) standards.

(b) Monitors MCO performance through on-site visits and other audits, and requires corrective action for deficiencies that are found.

(c) Requires MCOs to report annually on standardized clinical performance measures that are specified in the contract with MAA, and requires

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corrective action for substandard performance.

(d) Contracts with a professional review organization to conduct independent external review studies of selected health care and service delivery.

(e) Conducts enrollee satisfaction surveys.

(f) Annually publishes individual MCO performance information and primary care case management (PCCM) program performance information including certain clinical measures and enrollee satisfaction surveys and makes reports of site monitoring visits available upon request.

(2) MAA requires MCOs and PCCM providers to have a method to assure consideration of the unique needs of enrollees with chronic conditions. The method includes:

(a) Early identification;

(b) Timely access to health care; and

(c) Coordination of health service delivery and community linkages.

CLARIFYING INFORMATION

1. Program Definition — ACES Medical Coverage Code

TANF Cash	F01
TANF transitional medical	F02
Medical extensions	F03
TANF related CN Medicaid	F04
Newborn medical	F05
Children's CN Medicaid	F06
Long-term family care	K01
Legal guardian	H01
General assistance pregnant	P01
"S" medical	P02

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2. MAA mails managed care enrollment packets to most newly eligible clients. See **WORKER RESPONSIBILITIES** for a description of those instances when the worker must provide the client with the managed care enrollment packet. Managed care enrollment packets are different for:

   a. Healthy Options managed care plans; and

   b. Primary Care Case Management (PCCM). Clients may (might?) refer to this type of managed care as Washington State Health Network (WSHN).

3. The CSO is not responsible for enrolling, exempting, or disenrolling a managed care client in a plan or with a PCCM/WSHN health care provider. MAA is responsible for processing all such client requests.

4. Clients can call these MAA toll-free numbers for assistance:

   a. Medical Assistance Customer Service Center (MACSC): 1-800-562-3022. Staff responding to calls at this number:

      - Respond to general questions and concerns;
      - Enroll clients in the managed care plans;
      - Respond to client requests for changes in enrollment in managed care plans or with PCCM/WSHN providers.
      - Assist specific client groups with client-requested managed care exemption / enrollment termination. This line assists clients who are: American Indian/Alaska Native; Homeless; limited in English proficiency, or hearing impaired.

   b. MAA Exception Case Management Section (ECMS): 1-800-794-4360. Staff responding to calls at this number:

      - Handle exemptions, end-enrollments and complaints related to a managed care plan or related to PCCM/WSHN enrollments. CSO staff

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should not advise clients to seek **nor** should they tell a client they will be de-enrolled or exempted. These are client requests, MAA processes, and MAA decisions.

- Are responsible for managed care exemption and de-enrollment requests.
- Clients enrolled in managed care plans who have complaints about their plan, the provider or the medical care they are receiving, can call either their plan or they ECMS.
- Clients enrolled in PCCM/WSHN who have complaints can call ECMS.
- ECMS' mailing address is: ECMS, P.O. Box 45532, Olympia, WA 98504-5532.

5. A client enrolled with a managed care plan:

   a. Must follow the plan's rules and policies;

   b. Can register any disagreement with a plan or provider decision by filing an appeal with the plan. Clients also can file a hearing request with the department.

   c. Will have two medical ID cards. One is the DSHS Medical ID Card and one is a managed care plan ID card. The card from the managed care plan has the name of the client's primary care provider (PCP) and the plan's phone number.

6. A client enrolled with a PCCM/WSHN provider:

   a. Must obtain the approval of the PCCM / WSHN provider before they can receive most covered services;

   b. Can register a disagreement with a PCCM provider decision by filing a complaint with the Exception Case Management Section (ECMS). Clients also can file a hearing request with the department; and

   c. Will have the provider phone number on their DSHS Medical ID Card.

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Because they are not enrolled with a managed care plan PCCM / WSHN clients do not receive a second ID card from an outside party. All necessary information is on the DSHS Medical ID Card.

7. A client who is enrolled in managed care and is transferring residence from one county to another must:

   a. Contact both the CSO and the current managed care plan or PCCM / WSHN provider to:

      - Report the change of address;
      - Determine if a change in managed care plan or PCCM/WSHN is necessary; and
      - Obtain referrals from the primary care provider to new providers in the new residence area; and

   b. Contact MAA at 1-800-562-3022 to change managed care plans or PCCM / WSHN providers when the primary care provider confirms that need. This contact is very important to ensure the ongoing availability of medical care.

WORKER RESPONSIBILITIES

1. Inform the client of the department's managed care program when the managed care program affects the client.

2. Provide the current managed care enrollment packet to clients who:

   a. Are homeless;

   b. Use the CSO address as their mailing address;

   c. Have no mailing address;

   d. Require necessary supplemental accommodation (NSA); or

   e. Request a managed care enrollment packet from the CSO.

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3. Ensure the appropriate managed care indicators are placed on replacement DSHS Medical ID Cards (see Benefit Issuances).

4. Emergency health care is always available to a client with a life-threatening condition. If a managed care client is unsure of the need for emergency care or has other urgent questions, have them call their primary care provider's office. Someone is available for urgent questions 24 hours a day, seven days a week.

5. When the CSO receives a hearing request that involves managed care issues, notify MAA. MAA is responsible for the preparation of documentation and the presentation of the department's case at the hearing. MAA's hearing coordinators can be reached at 360-725-1398 or 360-725-1392.

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